FFS Claims Certification Testing Script

FFS Provider Claiming Readiness Testing consists of the following required phases:

1) Provider Setup and Testing Verification
2) Test clients Setup and authorization number
3) Claiming Cycle 1 Verification: Under Threshold and Over Threshold Claims Adjudication
4) Claiming Cycle 2 Verification: Replacement Claims
5) Claiming Cycle 3 Verification: Void Claims

1. Provider Setup and Testing Verification (Responsible Individuals: LACDMH and FFS Provider)

Provider and testing analyst will confirm the following information:

1) Submitter ID/DUNS Number.
2) 835 Defaults – information that will appear on the provider's 835s.
3) Provider has passed connectivity testing with DMH using the IBHIS TEST digital certificate.

2. Test clients Setup and authorization number (Responsible Individuals: FFS provider and LACDMH)

1) DMH provides three test clients information and the over threshold authorization number to be used for over threshold test claims
2) Provider uses the Authorization Number on the Fee-for-Service Funding Sources Authorization Table on page 4 of this document to submit under threshold test claims.

3. Claiming Cycle 1 Verification (Responsible Individuals: FFS Provider and LACDMH)

Following the validation of the setup of the provider in IBHIS, the provider will submit one claim for each client type list below using the funding source appropriate (MD or non-MD) authorization based on the discipline of the provider. Please adhere to the following naming convention: FFS _<ProviderInitial>_<DUNSnumber>_837P_Scen_<Scenario Number>_<Sequence Number>_<YYYYMMDD> .txt (e.g. FFS_ TB_000000000_837P_Scen1_001_20140201.txt)

Provider uses the list of test clients sent from DMH (via e-mail) to submit the claim for each client type listed below.

1) Medi-Cal Client - Financial Eligibility for Medi-Cal (10) and LA County (16).

a) Submit a claim with duration that is valid to have a payment to the provider using the funding source authorization. The list of funding source authorizations is included in the Funding Source Authorizations Table on page 4 of this document.
b) Submit a claim for med support services using the med support authorization number on the Funding Source Authorization Table on page 4 of this document. Please skip to c), if the provider does not provider med support services.
c) Submit an Over Threshold claim using the over threshold authorization number included in the list of test clients e-mailed from DMH to the provider.

2) Medicare and Medi-Cal (Medi-Medi) Client – Financial Eligibility for Medicare (12), Medi-Cal (10) and LA County (16).
   a) Submit a claim with duration that is valid to have a payment to the provider using the funding source authorization. The list of funding source authorizations is included in the Funding Source Authorization Table on page 4 of this document.
   b) Please include Medicare adjudication (COB) information as well for the Medicare payor on the 837.

3) Other Health Care (OHC) and Medi-Cal Client - Financial Eligibility for Healthcare LA (85), Medi-Cal (10) and LA County (16).
   a) Submit a claim with duration that is valid to have a payment to the provider using the funding source authorization. The list of funding source authorizations is included in the Funding Source Authorization Table on page 4 of this document.
   b) Please include COB information as well for the OHC payor on the 837.

   Claiming Cycle 1 verification will be considered complete when the provider has submitted an Approved claim for each category above. Upon completion of this step, the provider will be notified of the test status.

4. Claiming Cycle 2 Verification: Replacement Claims (Responsible Individuals: FFS Provider and LACDMH)

Please adhere to the following file naming convention:
FFS_<ProviderInitial>_<DUNSnumber>_837P_Scen_Repace_59_YYYYMMDD> .txt (e.g. FFS_TB_000000000_837P_Scen_Replace_59_20140201.txt)

1) Once the 1st cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit a replacement claim for one of the claims submitted in the 1st claim cycle. The Provider will replace a claim from Claiming Cycle 1 using the duplicate modifier '59'.
2) Claiming Cycle 2 verification will be considered complete when the replacement claim is successfully is approved.

5. *Claiming Cycle 3 Verification: Void Claims (Responsible Individuals: FFS Provider and LACDMH)*

Please adhere to the following file naming convention:
FFS_<ProviderInitial>_<DUNSnumber>_837P_Scen_Void_YYYYMMDD> .txt (e.g. FFS_TB_000000000_837P_Scen_Void_20140201.txt)

Once the 1st and 2nd cycles of Provider Claim Readiness have been validated and communicated to the Provider, the provider will submit a claim to void one of the claims submitted in the 1st or 2nd claim cycle. The Provider will void an Approved Claim from Claiming Cycle 1 or Claiming Cycle 2.

Claiming Cycle 3 verification will be considered complete when the claim is successfully voided.

Health Care Claim: Professional (837P) 2400/REF02 - Prior Authorization Number

The IBHIS system requires a valid authorization number for each submitted claim in an 837 file. Please refer to Section 6.1 of the HIPAA 837 Transaction Standard Companion guide for IBHIS for more details. It can be found at: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm

Funding Source Authorizations are used by Fee-for-Service providers for 8 under threshold sessions per trimester period and medication support services. For testing claims, with the exception of step 1c in Phase 2, Fee-For-Service providers need to use the authorization number from the table below based on the discipline, service type, and service date in the 837 claim file. It is important to note that the system will not allow the submission of test claims with future dates of service, so be sure to include the appropriate Funding Source Authorization Number in all test claims. These authorization numbers begin with an 'F', followed by a number.

Fee-for-Service Funding Source Authorization Table*

Provider Discipline Type	Service Type	Service Date Between	Authorization Number to use in 837(Claim)
Non MD	Under Threshold	5/1/2015 to 8/31/2015	F35
Non MD	Under Threshold	9/1/2015 to 12/31/2015	F36
Nurse Practitioner	Med Support	1/1/2015 to 12/31/2015	F38
MD	Under Threshold	5/1/2015 to 8/31/2015	F25
MD	Under Threshold	9/1/2015 to 12/31/2015	F37
MD	Med Support	1/1/2015 to 12/31/2015	F38

*This table is subject to change. Please check the following web site for the latest FFS claims Certification Test Script: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Readiness.htm.

Member Authorizations are specific to a client and used by Fee-for-Service providers for specific services and duration of time. For step 1c of Phase 3, Fee-for-Service providers use the approved Over Threshold Authorization number that is e-mailed to the provider by DMH. Member authorization numbers are all numeric.